Revised 2/06

FORM 5 PROVIDER AGREEMENT
INSTRUCTIONS

THE FORM 5 IS COMPRISED OF THREE PAGES. READ THESE INSTRUCTIONS CAREFULLY AND COMPLETE THE FORM 5 ACCORDING TO THESE 8 STEPS.

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Provider Number: __(1)____

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DIVISION OF ADULT & CHILD HEALTH IMPROVEMENT
DEPARTMENT FOR PUBLIC HEALTH

FIRST STEPS

PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the **(2)** day of **(2)**, 200___ by and between the Commonwealth of Kentucky, Division of Adult & Child Health Improvement, Dept. for Public Health, Kentucky Early Intervention Services, 2275 East Main, Frankfort, Kentucky 40621 hereinafter referred to as ACHI, and

(3)
(Name of Provider)

(4)
(Address, City, State, Zip of Provider)

hereinafter referred to as the Provider.

1. **Provider Number**:
   - **New Providers**: Leave the provider number blank (upper right hand corner of page 1). You will be assigned a provider number upon approval of your provider agreement by the Department for Public Health (DPH).
   - **Renewals/Addendums**: Enter the same provider number under which you are currently submitting bills to First Steps data manager.
2. **Date Contract Entered Into**: Leave month, day, & year blank (page 1). This will be completed by DPH upon approval of your contract.
3. **Name of Provider**: Enter the legal name of the entity requesting to become a First Steps Provider. (An entity can be either an agency or an independent provider.) This is the name under which your contract will be maintained in our records.
4. **Address of Provider**: Include your complete mailing address.

READ THE FULL TEXT OF THE PROVIDER AGREEMENT PAGES 1 AND 2 AND SIGN PAGE 3 AS SHOWN BELOW.

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Rev. 2/06

PROVIDER

BY: **(5)**
Authorized Signature (Provider)

NAME: **(Print)**

TITLE: _____

DATE: _____

DEPARTMENT FOR PUBLIC HEALTH
ADULT AND CHILD HEALTH IMPROVEMENT

BY: **(LEAVE BLANK)**
Authorized Signature (DPH)

NAME: Ruth Ann Shepherd, M.D.

TITLE: Director

DATE: _____

Contact Person: **(6. The contact person you designate will be responsible for maintaining communication with the First Steps staff.)**
NAME: **(6)**
TITLE: _____
ADDRESS: _____
PHONE #: _____
FAX #: _____
E-MAIL ADDRESS: _____

5. **Provider Signature (Authorized Signature)**: You must include an original signature. (Copies and electronic signatures cannot be accepted.) The signature should be of the individual authorized to commit the entity to providing services, adhering to First Steps regulations, policies, and procedures. Include the individual's title and the date signed.
6. **Contact Person**: Do not leave this field blank. As a First Steps provider contact person you will receive important information from time to time that must be communicated to personnel who deliver First steps services and/or are responsible for administrative operations. Because of the number of providers and costs involved, this person agrees to be the central clearinghouse in your entity for all First Steps related information. The contact person assumes responsibility for disseminating First Steps information to appropriate staff in a timely manner. At any time if there is a change in the contact person or address/phone/fax/e-mail address, you must notify DPH, First Steps in writing (e-mail, letter, fax) within 30 days of the change of information. All communications must include your assigned CBIS provider number.
7. **E-Mail Address and Fax Number of Contact Person:** All First Steps provider entities (agencies and independent practitioners) are required to provide a valid e-mail address and fax number. E-mail and fax may be used occasionally to alert providers to important changes that are posted

on the web site and to contact the provider regarding specific issues. At any time during the contract period that the e-mail address or fax number changes, you must notify DPH, First Steps in writing (e-mail, letter, fax) within 30 days of the new information. All communications must include your assigned provider ID.

READ CAREFULLY THE FULL TEXT IN THE PROVIDER AGREEMENT REGARDING VIOLATION OF TAX AND EMPLOYMENT LAWS.

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_____ The contractor has violated the provisions of one or more of the above statutes within the previous five (5) year period and has revealed such final determination(s) of violation(s). A list of such determination(s) is attached.

_____ The contractor has not violated any of the provisions of the above statutes within the previous five (5) year period.

FIRST PARTY:
DEPARTMENT FOR PUBLIC HEALTH
ADULT AND CHILD HEALTH IMPROVEMENT

SECOND PARTY (PROVIDER):

_____
Provider Name (print)

BY: _____
Provider Signature Date

8. **VIOLATION OF TAX AND EMPLOYMENT LAWS** (page 3 of Form 5: Provider Agreement): The section of the form shown above must be fully completed and signed by the same person who is the authorized party that signs the provider agreement. You must check whether you have or have not violated one or more of the referenced statutes. If you have violated one or more of the provisions, you must attach the statement of finding(s) and your written response to the finding(s). Sign as the Second Party.

ANY PART OF THIS FORM WHICH IS NOT COMPLETED CORRECTLY WILL RESULT IN THE ENITRE CONTRACT BEING RETURNED TO THE ENTITY FOR COMPLETION.

ORIGINAL SIGNATURE IS REQUIRED. DO NOT FAX OR ELECTRONICALLY SEND THE FORM 5: PROVIDER AGREEMENT